Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NOVA HEALTHCARE CENTERS
SUITE 280
110 CYPRESS-STATION
HOUSTON TX 77090

Respondent Name
TRAVELERS INDEMNITY CO

Carrier's Austin Representative
Box Number 05

MFDR Tracking Number
M4-11-0081-01

MFDR Date Received
August 9, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with the Texas Workers' Compensation Commission Rule 133.304, Subsections (K), (L), and (M), we are enclosing a copy of the complete medical bill for your reconsideration, copy of the explanation of benefits and a claim specific substantive explanation of why this claim should be reconsidered for reimbursement."

Amount in Dispute: $1,489.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for physical therapy sessions. The Provider sought and received preauthorization for 13 sessions of physical therapy. The Provider performed and billed the Carrier for a total of 21 sessions of physical therapy. The first three sessions were performed in the two weeks immediately following the date of injury, and so were exempt from the preauthorization under Rule 134.600(p)(5)(C). The Carrier reimbursed the Provider for these three sessions. The Provider then performed 13 sessions per the preauthorization approval. The Carrier reimbursed the Provider for these 13 sessions. The Provider then performed the sessions in dispute here. The Carrier disputed reimbursement for these sessions, as the Provider had exceeded the number of preauthorized sessions. The Provider subsequently requested preauthorization for additional sessions, which was denied as it exceeded ODG and did not meet medical necessity."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2010 through March 17, 2010	97110, 97112 and 97530	$1,489.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration
   - 198 – Payment denied/reduced for exceeded precertification/authorization

Issues

1. Did the requestor obtain preauthorization pursuant to 28 Texas Administrative Code § 134.600?
2. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. Per 28 Texas Administrative Code § 134.600 "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning..."

   The requestor seeks reimbursement for CPT code 97110, 97112 and 97530 rendered on March 9, 2010, March 11, 2010, March 12, 2010, March 16, 2010 and March 17, 2010.

   The requestor indicates that preauthorization was obtained for the disputed services rendered on the above noted dates.

   The insurance carrier denied the disputed services with denial reason "198 – Payment denied/reduced for exceeded precertification/authorization." The insurance carrier states in the position statement in pertinent part, "The Provider then performed 13 sessions per the preauthorization approval. The Carrier reimbursed the Provider for these 13 sessions. The Provider then performed the sessions in dispute here. The Carrier disputed reimbursement for these sessions, as the Provider had exceeded the number of preauthorized sessions..."

   Review of the documentation submitted by the insurance carrier supports that the requester exceeded the number of preauthorized sessions. Preauthorization was required for the services in dispute pursuant to 28 Texas Administrative Code §134.600 and insufficient documentation was submitted by the requestor to support that preauthorization was obtained, as a result, reimbursement cannot be recommended for the services in dispute.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for dates of service March 9, 2010, March 11, 2010, March 12, 2010, March 16, 2010 and March 17, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 5, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.